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Referring to psychological therapy services in Secondary NHS Mental Health Services –
how do mental health care professionals decide?

Abstract

Purpose: Evidence-based psychological therapies are available for severe and enduring mental health problems, but resources and access to these are limited within England. Practitioners in Community Mental Health Teams (CMHTs) can act as gatekeepers for access to psychological therapies for those in secondary care, but little is known about how they make referral decisions. The aim of the present study was to understand how CMHT practitioners make decisions about who to refer, or not, to secondary care Psychological Therapy Services (PTS).

Design: Eleven CMHT practitioners were interviewed to understand the decision-making processes underpinning their referrals, or otherwise, to a Psychological Therapy Service within NHS England. The data was analysed qualitatively using thematic analysis.

Findings: Thematic analysis resulted in ten sub-themes under three main themes of the self, the organisation and wider structure, and the service user. Results indicated that some participants referred automatically for psychological therapy if a service user asked, or if there was external pressure to refer, whilst others' decisions were informed by contextual information, such as the service user's ability to engage or change, risk status and limited organisational resources.

Originality/value: This study explores the decision making of multi-disciplinary professionals referring to PTS. The findings have important implications for understanding some of the factors that can influence patient access to psychological treatment in secondary care.

Keywords: Community Mental Health Team, Psychological Therapies Service, mental health practitioners, referrals, thematic analysis

1. Introduction

Psychological interventions are recommended by the National Institute for Health and Care Excellence (NICE) for a range of mental health problems including anxiety, depression, psychosis and personality disorders (NICE, 2005, 2009a, 2009b, 2011a, 2014). A systematic review found that between 5% and 66% of patients with mental health problems preferred psychotherapy or counselling to antidepressant medication (van Schaik et al., 2004). However, resources for psychological therapies are limited; a King's Fund briefing found that most services do not have sufficient staff to provide NICE recommended psychological interventions. Treatment waiting times for those with severe mental health problems are often over a year (Gilburt, 2015). This means that decisions have to be made within secondary care regarding who is referred for psychological therapies. Given that all service users in secondary care experience severe and enduring mental health problems and resources are limited, it is important to understand referral decisions to psychological therapies.

In England, people with serious mental health needs are usually supported in secondary care by Community Mental Health Teams (CMHT): multidisciplinary teams comprising social workers, mental health nurses, occupational therapists (OTs) and doctors (Gilburt, 2015). Practitioners in these teams co-ordinate care and collaborate with service users to create care-plans covering their goals. Within this role, they have considerable flexibility: they may be involved in resolving housing and social care issues and refer to psychiatrists for medication reviews and for psychological therapy. Psychological therapy services (PTS) may be part of a CMHT or organised within a separate secondary care psychology team, but service users do not usually have the option to self-refer and General Practitioners (GPs) cannot refer directly. This means that CMHT care co-ordinators typically act as gatekeepers to psychological interventions.

1.1. Decision Theory

To understand how decisions are made about referrals for psychological input, it is helpful to understand the processes involved in decision-making. Information processing theory suggests that we are highly selective about what information we attend to and how it is used. We use heuristics (simplification mechanisms) to select and process information (Beresford & Sloper, 2008). Therefore, people often only attend to factors that fall within a heuristic (e.g. mental health diagnosis, profession etc.) rather than making decisions based on all relevant factors. While heuristics are essential for quick decision-making, they can also lead to biases whereby incorrect assumptions inform actions. The dual process model of reasoning proposes that individuals mostly use a combination of heuristics to select and process information, but on occasion, they use complex cognitive processes (Eysenck & Keane, 2010). Kahneman and Frederick (2002) explain this in terms of two systems: the first system generates intuitive answers to judgement problems, which are monitored by the second system,

which may correct them. In relation to clinical referral decisions, this means that individuals may adopt heuristics for making quick decisions and may not always consider all relevant contextual information.

1.2. Decisions to Refer

Although dual processing theory gives an account of the processes involved in decision-making, it does not provide a framework for understanding the factors that influence decisions. Using a grounded theory approach with a sample of mental health nurses, Martin (1999) identified three inter-related concepts that influenced their clinical decision making with regards to mental health nursing care: the self, the service user and the social system. In relation to self, nurses' judgements were found to be influenced by their attitudes, beliefs, values and changing emotional states. The service user's personality also influenced nurses' judgements and, in relation to the social system, the structure of the healthcare system and the physical and social environment impacted on decision-making.

Research focusing on GPs decisions to refer to psychological services also highlights the interrelationship between the self, service user and social system. In relation to self, Fitch, Daw, Balmer and Gray (2008) found that referrals are more likely if the GP has a special interest in psychological wellbeing. Referrals are also influenced by service user factors; patients who were higher risk and who evoked negative responses in GPs were referred more frequently (Knight, 2003; Sigel & Leiper, 2004). In a qualitative study exploring how 14 GPs with an interest in mental health made decisions to refer to psychological therapy, Stavrou, Cape and Barker (2009) found that three interrelated themes distinguished patients who were referred and those who were not. These were (1) patient initiative (i.e. where patients had specifically requested additional help in relation to their problems); (2) patients seen as likely to benefit from psychological therapy (i.e. GPs prioritised those they perceived would benefit most); and (3) GPs' capacity to help, with those who felt that they had more expertise in mental health difficulties being less likely to refer patients to services. The authors report that most of the GPs who participated in this study had a special interest in mental health, so factors influencing their decision-making may differ to those GPs with other interests. Nevertheless, the study highlights the factors influencing GPs' decision to refer

Few studies have specifically explored the decision-making of CMHT practitioners when referring service users for psychological therapy. One study investigated CMHT practitioners' attitudes and decisions in relation to updated NICE guidelines on recommended treatments for schizophrenia (NICE, 2014) (Prytys, Garety, Jolley, Onwumere and Craig, 2011). They conducted semi-structured interviews with CMHT care co-ordinators, including nurses, social workers and occupational therapists. Similar to Martin (1999), they found an interaction between the factors relating to the practitioners themselves (including beliefs about treatments for psychosis), the service user (such as views of recovery in psychosis and service user refusal) and the system (such as doubts about relevance and applicability of clinical guidelines and role confusion). Practitioners were sometimes unsure of the value of psychological treatments for people with psychosis and were unable to

articulate their trust's referral criteria for psychological therapies or NICE guidelines, but they were guided by service users' views on treatment and limited resources. This study highlights some of the complexities of the gatekeeper role, specifically in terms of potential enablers and barriers to NICE recommended treatments for schizophrenia. As with the GP studies, because practitioners pay considerable attention to service users' requests for therapy, the study also highlights that service users' knowledge of psychological interventions for mental health difficulties is important to decision-making. Yet, studies of different population groups indicate that people's knowledge of psychological treatments for mental health are limited, meaning that some service users may not even be aware that psychological therapy could be available and effective and therefore will not request it (Gulliver, Griffiths & Christensen, 2010; Jorm, 2012; Wuthrich & Frei, 2015).

In summary, CMHT practitioners have an important role as gatekeepers for psychological therapies, yet little is known about how they decide to refer. Consequently, using a qualitative approach, this study aimed to understand the factors relating to mental health practitioners' beliefs and attitudes, the service user and social systems which influence their decisions to refer for psychological input.

2. Method

2.1. Description of the Service

The focus of this study is on the referral process between a CMHT and a secondary care PTS based within the same locality in the UK. The CMHT is a secondary mental health service which supports people with moderate to severe mental health difficulties within the community. Within the CMHT there are two categories of staff: those registered within a core health profession (e.g. social work, occupational therapy or mental health nursing) (referred to here as Mental Health Practitioners; MH-Ps) and non-registered staff with previous experience of working in mental health (referred to here as Mental Health Workers; MH-Ws).

The PTS comprises clinical psychologists, family therapists, psychodynamic psychotherapists and art psychotherapists. Consistent with government strategies, a main objective of the service is to work directly with service users to offer a range of evidence-based therapies consistent with NICE guidelines e.g. cognitive behavioural therapy for anxiety disorders and depression (NICE, 2014) and dialectical behaviour therapy for people diagnosed with personality disorders (NICE, 2009a). They also provide indirect psychological support and reflective space to professionals within the CMHT. Although the PTS provides a range of evidence-based therapies, service users can only access these therapies if a CMHT professionals make a referral. Referrals to PTS come from practitioners in the CMHT, which means that MH-Ps and MH-Ws are the gatekeepers to psychological input. Referrals for psychological input can take place both when a service user first comes into the CMHT and after a service user been supported by CMHT professionals for a period of time.

2.2. Participants

MH-Ws ($n=14$) and MH-Ps ($n=28$) with a minimum of six months' experience within the service were invited to participate in confidential interviews, which were fully anonymised prior to analysis. No monetary incentive was provided. Eleven participants were recruited, five females and six males. Six were MH-Ps; of these, four were mental health nurses and two were OTs. The MH-Ps had a range of 9 months to 3 years' experience. Five were MH-Ws who had experience in mental health, with a range of 9 months to 7 years' experience in the service.

2.3. Procedure

This study was reviewed and approved by a University Ethics Committee and the local NHS Trust Research and Development (R&D) Department. After participants had provided informed consent, interviews were conducted at the participants' work location. Participants were interviewed individually or in small groups, based upon participant availability. Six interviews were conducted: one with three participants, three with two participants and two with individuals. Interviews lasted between thirty minutes and one hour and were conducted by the first author. To ensure that the same topics were covered across interviews, a semi-structured interview schedule was used, guided by an adapted version of Martin's (1999) framework for clinical decision-making with the questions on self being specifically focused on attitudes and beliefs about psychological therapy (see Table 1).

Table 1 here

2.4. Analysis

The primary author acted as interviewer, transcriber and data analyst, and did not know any of the participants. The research was conducted from the perspective of "subtle realism" reflecting an assumption that there is an underlying realism which can be studied and that the goal of research is to reflect that reality (Mays and Pope, 2000). This means that a simple, largely unidirectional relationship is assumed between meaning, experience and language.

Interviews were analysed using thematic analysis, a flexible approach to qualitative analysis which enables the researcher to focus on specific research questions, as described by Braun and Clarke (2006). A deductive approach was taken so that the interviews were coded within a framework of the super-ordinate themes of Martin's (1999) study of community psychiatric nurses' decision-making: (1) organisation structure and wider social systems, (2) service user qualities and (3) self: beliefs and attitudes to psychological therapies. This top-down approach is consistent with the realist perspective and an analyst-driven approach, which gives a more detailed analysis of a specific aspect of the data.

Interviews were transcribed verbatim and read several times to increase familiarity with the data. Transcripts were imported into qualitative data analysis software (Nvivo 11) to facilitate analysis. Coding was

an iterative process: provisional codes were created in a coding tree under Martin's three overarching themes until all further text could be coded into existing codes. Codes with similar meanings were then combined to form sub-themes, with extracts being re-read to check for coherence and validity. Where themes were similar, they were merged and where they were inconsistent or lacking sufficient data they were discarded. The data set was re-read to check that themes reflected the interviews.

To validate the analysis, an independent researcher independently coded and generated sub-themes for 50% of the data. Themes were discussed and a final consensus was reached. Opinions about key meanings and themes were very similar between the researchers. As a final check, a different independent researcher coded quotations from one interview with an individual according to the themes and sub-themes. Inter-rater reliability for the coding of this one interview was calculated using Cohen's kappa (k). The overall k value was 0.70, indicating substantial agreement.

3. Results

The main and sub-themes are presented in Table 2 and described in detail below.

Table 2 here

3.1. Beliefs and Attitudes about Psychological Therapies

Three sub-themes were identified relating to participant's beliefs and attitudes about psychological therapies: (1) Most people could benefit; (2) PTS is not always the answer; and (3) I'm not a psychologist.

Most people could benefit

MH-W4: In an ideal world, quite a lot of people [would benefit from psychological therapies] really. That's why they come into the service because they need support with their mental health and their emotions.

Almost all participants expressed the view that "most people would benefit" from psychological therapy. This indicates that the prevailing view of psychological therapies within the CMHT was that they were of value and contrasts with a more ambivalent view of some of the participants in Prytys et al.'s (2010) study who were not sure of its efficacy for schizophrenia.

Nonetheless, participants indicated that there was a spectrum of usefulness of psychological therapies for different service users. One participant distinguishing between those who "needed" psychological therapies and those who could "benefit." Four participants acknowledged a gap between an ideal world in which most people on their caseload would receive therapy, and a world with limited resources in which not everyone

could, so priority decisions needed to be made. Furthermore, as suggested by the next subtheme there were occasions when participants thought PTS was less likely to be helpful.

PTS is not always the answer

A majority of participants expressed the view that PTS was not the answer for all service users. A common reason for this view was that participants felt that they were able to provide the help that was required. Some participants framed the help they could provide in practical terms. For example,

MH-W1: And it might be more about sorting out something a bit more practical with them, sorting out medication, housing, community activities, so on that sort of thing you wouldn't refer to PTS because there isn't a need.

Others suggested that in their role as MH-Ps or MH-Ws, participants were providing a therapeutic relationship and therefore there was not always a further requirement for psychological therapies.

MH-P1: Yeah, well we do it too. To a degree our work is that. Sometimes you've built a relationship with somebody and you think, "I'm doing the trick. You know, there's no point, really"

This view that PTS support was not necessary when participants were able to support either practically or through their relationship echoes similar views of some GPs in Stavrou et al.'s (2009) study who also spoke of there being times where they were doing enough.

I'm not a psychologist

The theme "I'm not a psychologist" illustrated a belief within practitioners that PTS had specialised knowledge and in their role in CMHT they were neither required nor expected to make specific decisions about psychological therapies.

MH-W2: I don't know what you should have and that's why you would have an assessment with a psychologist and sort of talk about that there, you know. Because I wouldn't pretend to know which therapy you should have or anything.

Although other participants, notably OTs and those who had been within the service for a longer time, said they had some idea of what psychological therapies were appropriate for particular service users, they also expressed the view that the ultimate responsibility for deciding about therapy lay with PTS:

MH-P6: It doesn't really matter if I think CBT is great or not, it is not for me...to make that decision.

MH-P4: Ultimately it's got to be [PTS's] understanding of what is useful for the person".

Perhaps because of this view that therapy choice was not up to them, no participants referred to NICE guidelines as a resource for guiding decisions about access to psychological therapy. This contrasts with the GPs in the Stavrou et al. (2009) study who stated that they sometimes referred people for specific therapy based on their presentation, but is consistent with the approach taken by the mental health practitioners in the Prytys et al. (2011) study.

Service User Qualities

In relation to service user's qualities, four sub-themes were identified: (1) View of therapy; (2) Stable enough to engage; (3) Need for change and (4) High risk

View of therapy

In the GP studies, GPs emphasised the importance of the service user's view of therapy in their decisions about referral (Sigel & Leiper, 2004; Stavrou et al., 2009) and NICE emphasises service user's agency as a decision-maker in their treatment (Nice, 2011b). In this study, service users' views of therapy were a significant factor in referrals with almost all participants indicating that a service user request was important in their decision-making. Yet participants differed in the weight they gave to the service user's therapy. Two participants indicated that they would only refer if the service user asked or there had been an external referral (see sub-theme below).

MH-W2: I think from my point of view, if someone asks me then I do. I have not come across someone where they haven't asked, and I've thought, "They really need it" yet.

Others took a more active role in decision-making, sometimes suggesting to a service user that they might want to consider therapy or deciding not to refer even when a service user had asked:

MH-P6: Yeah, so if [the service users] are asking, asking, asking. And I don't think this is appropriate and that's what I'm feeding back. But then ultimately, I just actually want to talk to [PTS].

While the participant here was clearly taking in to account more factors than the service user's request, it is clear that this could also be an uncomfortable position to hold without the support of PTS.

Stable enough to engage

The GPs in Sigel and Leiper's (2004) and Stavrou et al.'s (2009) study highlighted that before referring to psychological therapies, they would consider whether a service user was ready to engage. Similarly, it was

apparent from a majority of participants that the importance of engagement had been highlighted in discussions with PTS:

MH-P4: I have had conversations with [PTS] where they've talked about it, you know kind of other factors like being in stable accommodation and that sort of thing to start long term therapy if someone is homeless or in short term accommodation it is not usually a good time to start then.

Many participants indicated that if a service user could not engage with them, they would not refer:

MH-P2: Well, there are people that we find it hard to engage with and that's us going out to houses, GP surgeries, community centres... it's those types of service users, I really wouldn't refer to psychological therapies.

Participants also conveyed their knowledge about the difficulties that instability might bring for therapy conveying that it may mean that people cannot turn up for sessions or that they can't concentrate within the sessions or can only focus on the challenges of their circumstances. This indicated a thoughtful understanding of the importance of engagement.

Recognising need for change

Many participants spoke about referring only when service users were aware that they needed to change. This was sometimes framed as psychological insight.

MH-P2: They need insight to begin with... Yeah. An awareness that shifting something in them can make a change, rather than wanting the world to change, or other people to change.

Participants also discussed how service users' readiness to change affected both their decisions to refer and the course of therapy.

MH-W2: I think it's the individuals who want the most change who get the most out of it.

Conversely, several participants spoke of service users who were "stuck" who they would not refer to therapy. In talking about these service users, participants used emotive language, indicating how difficult they found this situation.

MH-P2 "Sometimes I think you're banging your head against it. It's not going to happen."

MH-W4: No. And it's hard because...you are permanently thinking that maybe you will someday be ready for this. But they are really stuck and going around in circles and have been for a long time.

High Risk Service Users

Participants also reported prioritising clients at risk of harm from themselves or others for psychological input because the service user needed emotional support. This is similar to the approach of GPs, who referred to psychological therapies where they thought that supporting the service users themselves was beyond their capabilities (Sigel & Leiper, 2004; Stavrou et al., 2009). Although one participant described the relief of having someone who was high risk because “it’s useful to have someone working alongside you” (MH-W2), there was some tension between the need for support with high risk service users and an awareness that they may not be able to engage in therapy. Some participants were able to resolve this by having psychological discussions with PTS without making a referral.

MH-W4: They might not fit the criteria for psychology, but it would be really helpful to have psychology discussion because you are really struggling.

Yet two participants expressed their frustration that those most at risk were seldom accepted for therapy.

MH-P6: Ummm... although the rational part of me is like, yeah, “that work probably wouldn’t be helpful right now.” When you have someone who is so complex and has all these needs, then it’s frustrating.

3.2. Organisation Structure and Wider Social Systems

Decisions to refer for psychological input were made in the context of the wider organisation and structure. Participants spoke of using team meetings, team formulation sessions and supervision to seek psychological input instead of making formal referrals. In relation to how structure of the service and the wider social system influenced referrals to PTS, three distinct sub-themes were identified: (1) External pressures to refer; (2) Uncertainty about the criteria for acceptance for psychological therapies; and (3) Limited resources.

External pressures

Participants reported that referrals for psychological therapies were driven by professionals and family members outside the recovery team. They indicated that when this occurred, they often automatically referred. So, although they completed the paperwork to refer, they did not see their role as decision-makers in the process. For example,

MH-P2: Sometimes people have come with a referral to psychological therapies. And they might have already had some sort of psychological therapies, like IAPT [Improving Access to

Psychological Therapies] and they've said that they need more intensive, more ongoing therapy or be suicidal or whatever.

All participants indicated that they referred to PTS in these circumstances, yet some expressed frustration at the pressure from psychiatrists or family members, noting that the service user may not be appropriate for therapy.

MH-W4: But sometimes there is pressure as well from sort of doctors' reviews. So, there have been some [psychiatrists] who say, "Yes, psychological therapies...." No one here at the moment, but there has been almost promises to the service user.

Interviewer: And is that a difficult thing?

MH-W4: Yeah, because it's kind of a process. It's not like we refer to psychological therapies and they say yes. It takes time and there's criteria.

The extract above illustrates how the actions of other professionals could sometimes raise service users' expectations that they would receive therapy, which participants could not always meet because PTS would determine service users' suitability for therapy.

Uncertainty about acceptance criteria

A minority of participants, including both mental health workers and mental health practitioners expressed uncertainty about criteria for referral.

MH-W3: I think myself and a lot of [MH-Ws] are still a bit hazy about the criteria for acceptance and whether someone is going to get on to PTS or not... there's historically been thresholds for not complex enough and too complex, or too unstable and trying to get within that band of acceptance has been quite trying (laughs).

This was also a problem reported by two MH-Ps:

MH-P6: I guess nobody has ever said... I've made up in my mind, it's entirely me who's made up who's going to benefit from psychological therapies.

These statements are consistent with Prytys et al.'s (2011) findings that practitioners were often unfamiliar with PTS referral criteria. They also indicate that previous experiences of PTS refusals of referrals for therapy could make them reluctant and uncomfortable to refer to PTS again.

Limited resources

Psychological services have limited resources (see Gilburt, 2015). Issues relating to access to services, such as length of waiting list, was a factor in decision making about referrals in other studies (Prytys et al., 2011; Sigel & Leiper, 2004; Stavrou et al., 2009) In this study, almost half the participants discussed how limited resources affected their decision-making, making it necessary for them to prioritise some service users over others:

MH-P5: For me yeah, because I just think, I want to make sure I'm getting the most prioritised people into it and want to make sure if I am getting somebody into it, it has to be somebody who really needs it.

One view was that some service users fell into a gap because, although they might benefit from therapy, others needed it more. This meant that they might not refer that service user, but they also conveyed a sense of regret for not doing so.

MH-P4: There are still people who perhaps might slip through the net almost because, they are not risky enough or not that much in need of therapy as some other people on our case load, but they are too unwell to see wellbeing therapies And so, there's a gap.

4. Discussion

This study aimed to understand how CMHT practitioners make decisions on whether to refer service users for psychological input, within Martin's (1999) framework: beliefs and attitudes to psychological therapies, service user qualities and organisation structure and wider social systems.

4.1. Beliefs and Attitudes to Psychological therapies

Almost all participants viewed psychological therapies as potentially valuable for service users, but their beliefs and attitudes about psychological therapies in the context of limited resources drove decisions about referral. For low risk service users, participants commented that there was not always a need for psychological therapies because 'they' (the practitioners) were capable of "doing the trick". This is a concern because people who do not present as higher risk, but are experiencing mental health problems severely enough to receive secondary care services, are potentially less likely to be referred for psychological therapies even when they may be suitable for them.

One sub-theme represented the view that MH-Ws and MH-Ps were "not psychologists" and therefore ought not to decide which treatments were beneficial. It is possible this needs to be discussed further within CMHTs, so that MH-Ps and MH-Ws are aware of NICE recommended treatments and that for certain problems, such as psychosis, psychological treatments should be offered (NICE, 2014).

4.2 Service User Qualities

For some participants, the service user asking for therapy or external pressures were the only drivers for referral. Although this has been shown to be an important factor in treatment outcomes (Chilvers et al., 2001), there is a concern that if MH-Ps and MH-Ws rely solely on service users requesting treatment, those who are suitable but are unaware of psychological treatments or are less vocal are less likely to be provided with access to NICE recommended treatments.

For other participants, factors about the service user, beliefs about the service and their own beliefs interacted, meaning their decisions to refer were more contextually based, as described in the second route outlined in dual process theory (Eysenck & Keane, 2010). In these cases, participants took into account not only the limited resources, but also the service user's ability to engage in therapy and openness to change.

4.2. Organisational Structure and Wider Systems

Decisions to refer for psychological input were made in the context of the wider organisation and structure in which there are limited resources and it is necessary to prioritise some service users over others. The issues raised in two sub-themes: external pressure to refer and uncertainty about criteria for referral, highlighted areas for potential improvement for CMHT and PTS teams. Some participants would automatically refer to psychological therapies if there were external pressures to refer. In the context of the dual process model of decision-making, this meant that they had an intuitive response (e.g. "I refer when requested by the psychiatrist") without taking into account wider contextual information (Kahneman & Frederick, 2002). In these cases, practitioners were no longer acting in a gatekeeper role. This is a potential issue that it is important for PTS to be aware of, so that they can educate and facilitate MH-Ps and MH-Ws to take contextual issues into account when making decisions about referrals. This would ensure that the "second system" of decision making is activated, so that those who would benefit from psychological input can gain access, rather than just on the basis of, for example, risk status.

MH-Ws and MH-Ps should also be clear on their gatekeeping role in relation to service users, rather than using a heuristic of "they ask, I refer, they don't ask, I don't refer". In addition, several participants expressed uncertainty about the criteria for referral. Participants also stated that previous experiences of PTS refusals of referrals for therapy could make them reluctant and uncomfortable to refer to PTS again. This is an important issue for CMHT and PTS teams as practitioners' past experiences of referral refusal could mean that some people appropriate for therapeutic support are not referred in future.

5. Practice Implications

These findings indicate have several implications for secondary mental health services in which CMHT practitioners are the gatekeepers to psychological therapies. Although some CMHT practitioners take an active role in deciding who to refer, others are more passive, relying on simple heuristics. This means that some people who may benefit from psychological therapy may not be referred. To encourage a culture of active

decision making in relation to referrals, PTS could agree upon and disseminate amongst CMHT practitioners a list of key issues relating to referral that need to be considered in relation to all service users. This will need to be agreed collectively, but may include the following:

- service user requests and referrals from other services; and
- whether a service user has a mental health diagnoses for which there are NICE recommended psychological treatments (e.g. psychosis) (NICE, 2014).
- service user engagement, insight into difficulties and motivation to change.

As part of this process, PTS should provide clear feedback when a referral is refused, including the reasons why and an indication of what might need to change to make. On a different note, PTS also may wish to provide a supportive role for clients who present risk of harm to themselves and others.

6. Limitations and further research

There are limitations of the current study. The sample size was relatively small and limited by the availability of participants and resources to complete the study. This means that different themes may have arisen if further interviews had been undertaken. In addition, the original intention was to conduct focus groups for participants, yet because of the difficulty in arranging meetings for larger groups, interviews were conducted with individuals and with groups of two and three and it is possible that people may have shared different views when talking within a group rather than as an individual. For example, it was noticeable that participants did not talk about more personal factors (such as feeling overworked or having personal problems) which may also have impacted on the likeliness of referral. This may also have been because the interview schedule did not include questions encouraging more personal responses. In addition, all participants were aware that the interviewer was a clinical psychologist and this may have resulted in them presenting a more positive view of psychological therapies than they otherwise might have done. In addition, not all people relevant to the decision-making process were interviewed. Participants reported that at times there are external pressures from other professionals, such as psychiatrists, to refer service users to PTS. As such, it is a potential limitation of this study that the decision-making processes of these professionals were not explored.

Further research could explore in more detail how more personal characteristics of CMHT staff may affect their referral decision-making (e.g. feelings of being inexperienced, work-based stress, personal difficulties and family pressures). Another area of potential research is the decision-making processes of other professionals, such as psychiatrists and general practitioners.

7. Conclusion

Many different factors influenced CMHT practitioners' decisions to refer to PTS, under the themes of the practitioners themselves, service users and the context of the service. These themes can be understood in the

context of information processing theory. Participants indicating that the presence of certain factors, such as external pressures, would always lead them to refer to PTS, is indicative of use of the first system within the dual processing model, for quick intuitive decisions using a heuristic (Kahneman & Frederick, 2002). However, other participants employed the second system, taking into account contextual information before making a decision. There are implications for CMHT practice around this such as reviewing and supporting gatekeeping role of MH-Ps and MH-Ws.

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Table 1

Questions for semi-structured interviews

<i>Questions and prompts</i>	
1.	How do you decide who to refer to CPI?
2.	In the cases of service users whom you don't refer, what helps you decide you are not going to?
3.	In relation to the referral structure and external systems – what makes it easy to make referrals? Are there things which make it more difficult? Could it be made easier?
4.	Is there anything about a service user which makes you more likely to refer? Do you ever discuss psychological therapies with service users to find out what they think? What kind of thing makes it less likely for you to refer?
5.	Who do you believe benefits most from psychological therapies? Are there some things or people you believe are just not appropriate for psychological therapies?

Table 2. Main and sub-themes representing the decision-making process underpinning referrals to PTS

<i>Main theme and definition</i>	<i>Sub-theme</i>	<i>Nos of participant contributions</i>

Self: Beliefs and attitudes about psychological therapies – this theme focused specifically on participants’ attitudes to psychological therapy rather than looking more widely at their beliefs and attitudes.	Most people could benefit	10/11 participants
	PTS is not always the answer	9/11 participants
	I’m not a psychologist	7/11 participants
Service user qualities – focusing on what made referrals more or less likely	View of therapy	8/11 participants
	Stable enough to engage	9/11 participants
	Recognising need to change	9/11 participants
	High risk service users	8/11 participants
Organisational structure and wider social structures- focused on barriers and aids to referral	External pressures	9/11 participants
	Uncertainty about acceptance criteria	4/11 participants
	Limits in resources	11/11 participants